LIFE SKILLS SUPPORT CENTER QUESTIONNAIRE

This form is covered by the Privacy Act of 1974

This questionnaire is designed to help your provider understand more about you. By completing these questions as completely and honestly as you can, we will be able to offer you the best assistance possible. This form will be included in your Life Skills chart; it will **not** be included in your outpatient medical chart.

1. GENERAL INFORMATION:

Name: Sponsor's Name: Sex: ☐Male ☐Female

Address: Occupation:

Phone #:(duty) (home) Date of Birth: Age:

If referred, by whom were you referred: Military Status:
☐CADET ☐AD ☐DEP ☐RET ☐RES ☐ CIV ☐ TDRL

Marital Status: ☐ Single ☐ Engaged ☐Married ☐Living with Someone
☐Divorced ☐Widowed ☐Remarried ☐ Significant Relationship

Religious Preference:

Race/Ethnicity: Do you have other health insurance? ☐ Yes ☐ No

ACTIVE DUTY MILITARY: (mark all that apply)
PRP ☐ SCI ☐ FLYING ☐ WEAPONS ☐ MOBILITY ☐ Not Applicable ☐ Date of Separation:

Branch of Service: Rank: SSN:

Commander: First Shirt:

Time in Service : Date on Station: Squadron: Present Duty Station:

2. PRIMARY PROBLEM(S)/CONCERN(S):

Briefly, what are the problem(s) or concern(s) that brought you to this clinic?

What led to your decision to seek help now?

On the scale below please check the description that best estimates the overall impact on you of your problem(s):
☐Mildly Upsetting ☐Moderately Upsetting ☐Very Severe ☐Extremely Severe

When did your problem(s) begin (give dates):

Please describe any significant events occurring at that time, or since then, which may relate to the problem(s):

What solution(s) to your problem(s) have been most helpful?

Have you been in counseling or mental health treatment before (include inpatient hospital, school, or chaplain services)?
☐Yes ☐No (If yes, what were you treated for? When? And was it helpful?)

Does any member of your family suffer from alcoholism, depression, anxiety, or anything else that might be considered a mental health problem? If yes, did they receive any inpatient or outpatient treatment? ☐Yes ☐No (If yes, please explain)

Have you or anyone in your family had any incidents of physical, emotional, or sexual maltreatment? ☐Yes ☐No (If yes, please explain)

SAFETY

Have you ever attempted suicide? If yes, when: How?
☐Yes ☐No

Has any relative attempted or committed suicide? ☐Yes ☐No (If yes, please explain)

Has your current situation made you feel so distressed you wish you would no wake up or be around anymore?	Yes / No
Has your current situation made you feel so distressed that you've thought of ending your life? If "Yes", what has stopped you?	Yes / No
Have you ever tried to intentionally hurt yourself?	Yes / No
Has your current situation made you so distressed you've thought about harming someone else?	Yes / No
Have you ever intentionally harmed someone else?	Yes / No
Have you ever destroyed property out of anger?	Yes / No

3. PERSONAL, SOCIAL AND EDUCATIONAL HISTORY:

What was the last grade of education completed/degrees earned?	Academic performance: ☐ below average ☐ average ☐ above average

Check any of the following that applied during your childhood and adolescence:

☐ Happy Childhood	☐ Hyperactivity	☐ Drug or Alcohol Abuse	☐ Legal Trouble
☐ Unhappy Childhood	☐ Behavioral Problems	☐ Medical Problems	☐ Physical Abuse
☐ Emotional Problems	☐ Family Problems	☐ School Problems	☐ Sexual Abuse
☐ Attention Problems	☐ Other:		

Where were you born and raised?
Who did you grow up with?

IF YOU HAVE A SIGNIFICANT OTHER:	How long have you been together?	Their age:

What problem(s) *if any* do you see in your relationship?	What strengths do you see in your relationship?
How satisfied are you with your current relationship?	How satisfied do you think your spouse/partner is with the relationship?

IF DIVORCED, what led to your divorce?

If you have children, or others living in your home, please provide the following information:

NAME	AGE	SEX	RELATIONSHIP

Is your present sex life satisfactory? ☐ Yes ☐ No (If no, please explain.)

Are there any problems in your relationships with people at work? ☐ Yes ☐ No (If yes, please describe)

What problems, if any, do you find with your job or occupation?

Are you having or ever had any financial problems? (If yes, please explain)

Please list any legal or disciplinary problems you have had (including LOCs, LORs, Art 15s, Control Roster, UIF)

What do you like to do for leisure?

What are you good at (talents, and strengths)?

What are your goals for the future?

4. BEHAVIOR: Check any of the following behaviors that apply to you **recently**:

☐ Overeat	☐ Smoke	☐ Take Too Many Risks	☐ Withdrawal	☐ Drinking Too Much
☐ Mood Swings	☐ Crying	☐ Odd Behavior	☐ Procrastinate	☐ Eating Problems
☐ Can't Keep a Job	☐ Aggressive	☐ Sleep Disturbances	☐ Work Too Hard	☐ Impulsive
☐ Phobia/Fears	☐ Vomiting	☐ Loss of Control		
☐ Concentration Problems	☐ Compulsions	☐ Temper Outbursts	☐ Other:	

5. FEELINGS: Check any of the following feelings that often apply to you **recently**:

☐ Angry	☐ Annoyed	☐ Sad	☐ Depressed	☐ Anxious	☐ Contented	☐ Numb/Nothing
☐ Fearful	☐ Panicky	☐ Energetic	☐ Envy	☐ Guilty	☐ Excited	☐ Worthless
☐ Happy	☐ Conflict	☐ Regretful	☐ Hopeless	☐ Hopeful	☐ Optimistic	☐ Irritability
☐ Helpless	☐ Relaxed	☐ Jealous	☐ Unhappy	☐ Bored	☐ Tense	
☐ Restless	☐ Lonely	☐ Other:				

6. PHYSICAL/MEDICAL: Check any of the following that often apply to you and that you find troublesome:

☐ Headaches	☐ Dizziness	☐ Palpitations	☐ Sexual Problems
☐ Numbness	☐ Unable to Relax	☐ Bowel/Bladder Problems	☐ Visual Problems
☐ Stomach Trouble	☐ Fainting	☐ Fatigue	☐ Back Pain
☐ Tremors	☐ Hearing Problems	☐ Blackouts	☐ Skin Problems
☐ Dry Mouth	☐ Chest Pains	☐ Rapid Heart Beat	☐ Sweating
☐ Tension	☐ Tic/Twitches	☐ Head Injury	☐ Muscle Spasms

☐ Other:

Do you have any current concerns about your physical health and/or chronic health problems? ☐ Yes ☐ No (If yes, please describe)

Year of your last physical:

Please list any non-psychiatric medications you are currently taking or have taken during the past 6 months (please **underline** those you are currently taking; *including aspirin, vitamin supplements, herbs, birth control pills, or any medications that were prescribed*)

Please list any medications you have taken for mental health treatment:

Please list any allergies:

Nutrition/Health: Has your weight changed in the last few months? ☐ Yes ☐ No ☐ Gained ☐ Lost

(If yes, how much?) What caused the loss or gain?

Do you get regular physical exercise? ☐ Yes ☐ No (If yes, what type and how often)

Appetite: How many meals per day do you eat? _____ Do you consider your diet to be healthy? ☐ Yes ☐ No

Does your diet include a balance of fruits, vegetables, grains, etc.? ☐ Yes ☐ No

Do you practice relaxation or meditation regularly? ☐ Yes ☐ No

Please write the number here that represents the amount of physical pain you feel now_____ Type of pain:_____

If the number isn't 0, would you like a referral to your primary care provider? ☐ Yes ☐ No

Mark the boxes which apply to you and provide the information requested:

	Yes	No	Current	Past	How Often?	How Much?
Tobacco Use	☐	☐	☐	☐		
Coffee/Caffeine Beverages	☐	☐	☐	☐		
Drug Use	☐	☐	☐	☐		

Are you bothered by thoughts, dreams or images that occur over and over again? ☐Yes ☐No (If yes, please describe)

Do you sometimes avoid certain topic or situations that remind you of the past? ☐Yes ☐No (If yes, please describe)

Do you find that you are easily startled and/or always on the alert for danger? ☐Yes ☐No (If yes, please describe)

ALCOHOL USE

Has there been an increase in the amount of your drinking during the past six months?	Yes	No
Have you recently cut back or felt you should?	Yes	No
Have you recently felt annoyed by people criticizing your drinking?	Yes	No
Have you recently felt guilty or bad about your drinking?	Yes	No
Have you ever taken a drink to relieve a hangover or calm your nerves (for example, morning drinking, relieve anxiety, etc.)?	Yes	No

Please list any unique speech, hearing, learning, occupational/physical disability or pain management needs you feel should be considered in making your treatment plan:

How do you learn best, (e.g., reading, lecture etc).? ☐ Listening ☐ Seeing ☐ Hands-on ☐ Other:_____

Any special religious or cultural factors you would like us to be aware of?

How satisfied are you with your religious faith or spirituality?
☐Very Satisfied ☐Unsatisfied ☐Neutral ☐Satisfied ☐Very Unsatisfied

How satisfied are you with the support you are getting from your family?
☐Very Satisfied ☐Unsatisfied ☐Neutral ☐Satisfied ☐Very Unsatisfied

How have your current difficulties affected your religious or spiritual practices?

How have your current difficulties affected your relationships with family?

Sleep:
Hours/night on average: _____ Is this a change in your normal sleep pattern? ☐Yes ☐No
If so, how long has this been a change?

Energy: Do you feel tired easily? ☐Yes ☐No General energy level is: Low Medium High
Concentration: ☐good ☐mostly good ☐poor

Are you less interested in your usual activities? ☐No ☐Somewhat less ☐ A lot less

TREATMENT GOALS CHECKLIST

In order to offer you the treatment opportunities most in line with your reasons for coming to this clinic, we would appreciate your completing the following list of treatment goals. Please check the box of those goals that apply to you.

In coming to this clinic, I would like to concentrate on:

☐ 1	Reducing my fear of _____.	☐26	Improving my relationship with my (circle) spouse/children/friends/coworkers/others.
☐ 2	Having more pleasurable activities.	☐27	Talking out a pending decision.
☐ 3	Reducing my sensitivity to possible criticism.	☐28	Learning problem solving/decision making techniques.
☐ 4	Learning how to relax.	☐29	Expressing myself more assertively.
☐ 5	Better managing my health.	☐30	Reducing family difficulties.
☐ 6	Better tolerating my mistakes.	☐31	Reducing job difficulties.
☐ 7	Better tolerating others' mistakes.	☐32	Better managing my temper.
☐ 8	Feeling less guilty.	☐33	Taking initiative more often.
☐ 9	Feeling less depressed.	☐34	Receiving medication help.
☐10	Better accepting the loss/death of _____.	☐35	Decreasing procrastinating.
☐11	Increasing my conversation skills.	☐36	Better managing time.
☐12	Learning how I come across to others.	☐37	Decreasing trying to be perfect.
☐13	Not taking disappointments so hard.	☐38	Not reacting so emotionally.
☐14	Doubting myself less.	☐39	Allowing myself to express feelings more.
☐15	Thinking more positively.	☐40	Feeling more self-confident.
☐16	Discussing my feelings of harming myself.	☐41	Improving my sexual relationship.
☐17	Discussing my feelings of harming others.	☐42	Controlling my eating or weight.
☐18	Adjusting better to a recent change or Incident. (specify) _____.	☐43	Adopting a more healthy attitude about _____.
☐19	Controlling my habit of _____.	☐44	Adjusting better to a past incident.
☐20	Controlling my use of drugs.	☐45	Becoming more optimistic.
☐21	Better managing my pain.	☐46	Controlling my alcohol use.
☐22	Learning how to improve friendships.	☐47	Improving my self-awareness.
☐23	Improving my sleep.	☐48	Worrying less about _____.
☐24	Learning more effective parenting skills.	☐49	Other (specify):
☐25	Reducing uncomfortable thoughts of _____.		

Please review your list and decide which THREE goals you most wish to discuss/change at this time. My THREE most important goals are (write in the goal numbers):

FIRST _____ SECOND _____ THIRD_____

SIGNATURE: DATE:

THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974

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